DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

PERSONAL CARE SERVICES/COST REPORT
Exemption Form

Due Date: JULY 27, 2007

PLEASE COMPLETE AND SUBMIT TO DMA

_____
(Agency Name)

_____
(Agency Address)

_____
(Agency's Fax #)

_____
(Agency Phone #)

_____
(Agency Email Address)

_____ _____
(Medicaid Provider #s) (NPI #)

This agency is requesting exemption for the submission of the 2006 Cost Report for the following reason(s):

□ The agency received less than $50,000 in Medicaid payments (PCS, PCS-Plus & CAP-DA revenues combined) for the 2006 reporting period.

□ The agency was operative six months or less and/or has received less than $50,000 in PCS, PCS-Plus & CAP-DA Medicaid revenues.

□ Other-

_____
_____

_____ _____
(Signature of the Provider Agency) Date

_____
(Printed Name)

Exemption request granted - YES or NO

_____ _____
Signature of the DMA Analyst Date

Mailing Address (for regular mail):
DHHS-DMA-Finance Management, Attn: Betty Jones,
2501 Mail Service Center, Raleigh, NC 27699-2501

Fax # - 919-715-2209
Office # 919-855-4203